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TABLE OF CONTENTS

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THE Rh FACTOR—ITS ROLE IN ERYTHROBLASTOSIS-FETALIS, AND INTRA-GROUP TRANSFUSION REACTIONS*

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IN 1940 Landsteiner and Wiener[1] observed that after rabbits were injected with the red blood cells of rhesus monkeys an antibody developed in the serum of the injected rabbits that agglutinated rhesus red cells. This antigenic substance present in the red cells of these monkeys they designated as the Rh factor. They then found that by means of this new immune serum all human bloods could be divided into two sorts, one (85 percent) containing this Rh factor and therefore called Rh positive and the other (15 per cent) lacking it and therefore called Rh negative.

This Rh factor when present is a property of the red cells only, in contrast to the A & B factors of the common blood groups which are present in all the tissue cells and in the blood serum and other body fluids. The anti Rh agglutinin is an acquired antibody in contrast to the anti A and anti B agglutinins which are naturally or normally present.

There are two practical applications[2] of this new knowledge concerning the Rh factor: (1) It explains certain heretofore puzzling intragroup hemolytic transfusion reactions and provides a means of preventing them and (2) It furnishes an adequate explanation as to the etiology and pathogenesis of erythroblastosis of the new born.

Since the discovery of the iso agglutinins in blood and the subsequent use of donors of the same group as the recipient, transfusion reactions have been reduced to a minimum. However, occasional severe and even fatal transfusion reactions have occurred following the use of blood from donors of the same group as the patient. A series of these intragroup reactions were reported and explained by Wiener and Peters[3] in 1940 as due to isoimmunization of Rh negative patients by transfusion with Rh positive cells.

The way in which this is brought about is explained thus[2]—the transfused Rh positive erythrocytes are antigenically active and stimulate the production of anti-Rh antibodies in the blood of the Rh negative recipient. There is no reaction to the first transfusion because as yet there are no antibodies present. However, a second, third, or some subsequent transfusion may result in a severe reaction. In other words an interval of time must elapse sufficient to permit the development of the anti Rh antibodies in the patient's blood. This interval of time is variable.

Such reactions do not occur often because multiple transfusions are not frequent, a certain portion of such incompatibilities are eliminated by the usual methods of cross matching, most individuals (85 per cent) are Rh positive and there is marked variation in the ability of Rh negative individuals to develop the antibodies. (*Charts 1 and 2*)

It has frequently been noted that such intragroup transfusion reactions occur much more frequently in pregnant women. Most important is the fact that in this group the accident occurs as a result of the *first* transfusion. Analysis of the histories of these women revealed a high incidence of spontaneous abortions, miscarriage, still births and neonatal deaths.[4] Thus there seemed to be some relationship between these obstetrical mishaps and the transfusion reactions. This relationship was explained when it was found that certain of these women had had one or more babies with the familial disease, Erythroblastosis fetalis, which is characterized by a hemoyltic process initiated in utero. We shall come back to that shortly.

Since these intragroup hemolytic transfusion reactions in pregnant women occur following the first transfusion, it is clear that something must have occurred during and resulting from the pregnancy that made them susceptible. Levine[5] studied sixteen pregnant women who had had such trans-

*Presented at the meeting of the Providence Medical Association, October 4, 1943.

fusion reactions, five of which were fatal. All of these women were Rh negative and their husbands were Rh positive. In pregnancy it is assumed that the father who is Rh positive transmits this factor to the fetus. From the fetus Rh positive red blood cells escape into the blood of the mother and stimulate her to produce the immune agglutinins. In this way she is conditioned for a hemolytic reaction following a transfusion with Rh positive blood (frequently from the husband). (*Chart 3*)

Erythroblastosis fetalis exhibits some of the following characteristics in the fetus: A profound, usually fatal anemia, caused by the destruction of red cells. Hyperactivity of the blood forming organs in an effort to replace the destroyed red cells. This hyperactivity results in the appearance in the blood stream of many immature nucleated red cells (normoblasts). Enlargement of the liver and spleen. Enlargement of the placenta which may be two or three times its normal size. Prenatal jaundice with a greenish staining of the amniotic fluid, placenta, cord and membranes. Pronounced edema of the fetus including the placenta. The repeated occurrence of the disease in the offspring in all or several pregnancies of a particular mother. A high incidence of abortions, miscarriages, premature labors and stillbirths in mothers who have given birth to erythroblastotic babies.

All of the foregoing characteristics have been known for several years. An investigation of the Rh factor has established still another characteristic: In over 90 per cent of cases of erythroblastosis the mother is Rh negative and the father and baby are Rh positive. Levine[5] and his co-workers studied the blood of one hundred and eleven mothers who had had babies in whom a diagnosis of erythroblastosis fetalis was established. Of these, 101, or 91 per cent, were Rh negative and only 9 Rh positive.

Burnham[6] explains the pathogenesis of erythroblastosis as follows: "There is present in the fetal red blood cells an antigen inherited from the father which is lacking in the mother. This antigen diffuses from the child into the mother's circulation, stimulating the formation of destructive antibodies. These antibodies, like other maternal antibodies (for example diphtheria antitoxin) also diffuse readily into the fetal circulation, where they can attack the red cells which contain the antigen, thereby causing erythroblastosis." (*Chart 4*)

Fetuses that survive 9 months of exposure to this antibody in utero and are born alive are likely to show erythroblastosis fetalis in some of its various forms such as hydrops neonatorum, icterus gravis, or congenital anemia. Many do not survive this long and are born dead prematurely. Future investigations of still births will probably show that many are Rh positive and their mothers Rh negative.

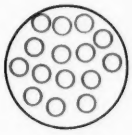
From the figures given at the beginning of this paper it has been calculated that in 12 per cent of all matings the husband is Rh positive and the wife Rh negative. Yet statistics also show that only one out of every 438 babies suffer from erythroblastosis. There are probably several reasons for this low incidence. It seems probable that in many cases the placental barrier between the fetal and maternal circulations may be so efficient as to prevent the passage of the antigenic Rh substance from the fetus into the mother. All Rh negative mothers may not be capable of producing the anti-Rh antibodies. In the production of the antibodies in rabbits by inoculation with monkey red blood cells it is found that only one rabbit out of ten will produce a potent agglutinin. It is quite probable that there is a similar variation in Rh negative women. One or two previous pregnancies seem to be necessary to cause sufficient antagonistic substances in the mother's blood to affect the baby, so that first born babies are not likely to be erythroblastotic. The present tendency toward small families therefore lessens the incidence. Since many of these pregnancies result in abortion and miscarriage the condition is not always diagnosed. A certain number of Rh positive fathers are hetero-zygous and therefore may not transmit the Rh factor to the fetus. The Rh factor has been shown to be inherited as a Mendelian dominant.[7]

From a study of the role of the Rh factor in the causation of erythroblastosis and intragroup reactions following repeated transfusions the following observations are of practical significance. There is one chance in seven that a given patient is Rh negative. Patients having reactions against blood in their own blood group are usually Rh negative patients who have had one previous transfusion with Rh positive blood or if the reaction takes place with the first transfusion are mothers of babies suffering from erythroblastosis of greater or less severity. A patient likely to require repeated transfusions should be tested for the Rh factor and if found to be Rh negative should be transfused with Rh negative blood only. An Rh negative patient who has had a reaction from Rh positive blood can be safely transfused with Rh negative blood.

continued on page 244

SYMBOLS

Rh+ 85%



Rh— 15%

Haemolysis

CHART I

(Rh—) + (Rh+)

Formation by Rh— blood of substances antagonistic to Rh+ blood

Rh— after Rh+ Transfusion

Antagonistic substance persistent in Rh— blood for weeks or longer after first transfusion with Rh+ blood

CHART II

Mechanism of Rh Factor in Producing Transfusion Reactions in Men, and in Women who have never been pregnant

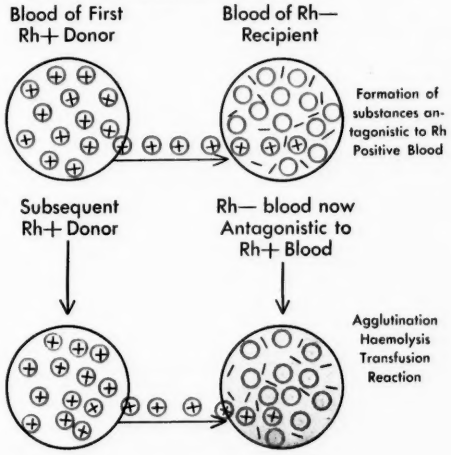
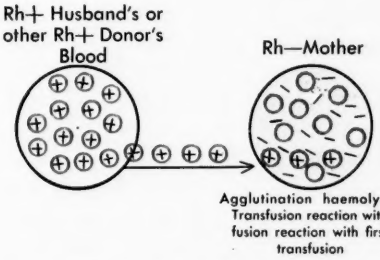


CHART III

Mechanism of Transfusion Reaction in Mother of Erythroblastic Foetus

Blood of Mother (always Rh—) recently delivered of, or carrying, an Erythroblastic Foetus

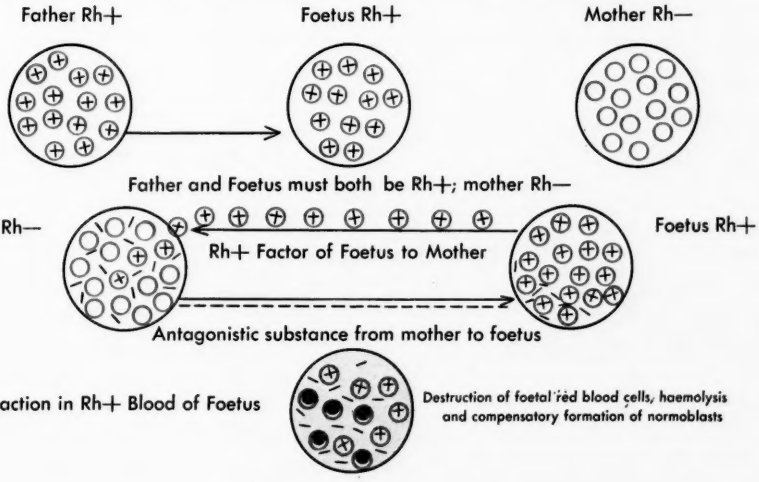
Contains substance antagonistic to Rh+ Blood



Agglutination haemolysis. Transfusion reaction with fusion reaction with first transfusion

Note: Women who have had stillbirths of unknown cause, repeated miscarriage or eclampsia show a high incidence of Rh— findings

CHART IV Mechanism of Rh Factor in Production of Erythroblastosis



End Reaction in Rh+ Blood of Foetus

Destruction of foetal red blood cells, haemolysis and compensatory formation of normoblasts

A mother of an erythroblastotic fetus is always Rh negative and has, in effect, had a transfusion of Rh positive blood from the fetus. She may therefore have a reaction with the first transfusion with Rh positive blood and should be transfused only with Rh negative blood.

There is an abnormally high incidence of repeated abortion, miscarriages, premature labor and stillbirths among women known to be Rh negative. Patients giving such a history should be suspects and should not be transfused without their blood being tested for Rh factor.

The Rh factor is present in the red cells and not in the serum. In cases of such urgency that it is impracticable to employ the time consuming Rh test, plasma and not whole blood should be used for emergency transfusion. Every gynecological service and especially every obstetrical service should have a list of Rh negative donors.

The Rh positive blood of a newborn erythroblastotic infant continues for some time after birth to destroy Rh positive blood cells. Therefore Rh negative blood should be used in transfusing known or suspected cases but the Rh negative blood of the mother should not be used as it may contain substances inimical to the blood of the newborn.

Tests for the Rh factor may aid in the diagnosis of erythroblastosis in anemias of the newborn in which the disease is not of sufficient severity to cause the typical blood picture and the classical signs.

Anti Rh substances have been demonstrated in the blood of the mothers of erythroblastotic infants for periods up to three years post partum. Cases are on record in which there was a blood transfusion reaction some years after a previous transfusion. Therefore, any patient, man or woman, who has had a previous transfusion should be tested for the Rh factor and if Rh negative should be transfused with Rh negative blood and any woman who gives a history of having had an erythroblastotic infant, repeated abortions, miscarriages, premature labors, stillbirths or neonatal deaths should be suspected of being Rh negative and transfused with blood from Rh negative donors.

If the above precautions are observed the incidence of intra-group hemolytic transfusion reactions should be reduced by 90 per cent. There still remain 10 per cent that are unexplained.

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INDEX OF ADVERTISERS

THE WAGNER-MURRAY-DINGELL ACT

A Preliminary Report by the Committee on Public Laws of the Rhode Island Medical Society on the Social Security Amendment Now Before Congress

THERE have been many fine analyses and reports, notably the one prepared by the Bureau of Legal Medicine of the American Medical Association, on the Wagner-Murray-Dingwell Act now before Congress. Merely to reiterate in this report the provisions of the act and the excellent observations already made by authorities would appear to avail little. Therefore this Committee has concerned itself in this preliminary report with what it believes to be the basic purpose of the proposed legislation, and has endeavored to determine whether this purpose can be achieved in a manner that will result in better health for the people of this country, and more particularly the people of the State of Rhode Island.

Disposing, therefore, without discussion, of the apparent faulty mechanism of the proposed act which would make the Surgeon General of the United States the supreme head of all medical and health services, even to the extent of controlling the general practice of medicine, this Committee recognizes the following as the objective sought by the Title IX of the Wagner Act (which incidentally is the only part of the legislation considered in this preliminary study):

The development by means of the insurance principle of a program nationwide in scope whereby medical and hospital care may be budgeted so that each family carries a budgeted rather than, as at present, a variable risk, thus assuring that everyone will have the money to pay for medical and hospital care, and as a corollary to this theory, that everyone will seek medical attention promptly and good health will thereby be attained to a greater extent than heretofore.

In considering this objective this Committee omits discussion of the vast new bureaucracy which would be created by the adoption of a national insurance scheme to include health provisions, and it concerns itself with the primary concern of the medical profession: Will such a program actually give better health care, or for that matter provide the best return to the public for the public funds expended? As a strictly insurance program whereby moneys will be distributed on a nationwide basis to all individuals equally there is probably little question that this phase of the plan is workable, but that the better distribution of funds will result in better medical or hospital care is not proved by any authority advocating passage of the Act with Title IX included.

We think that medical and hospital care for the public would not be improved by this program. There is little need in this report to cite what is only too well-known—the facts relative to the good health enjoyed by the people of this country as compared with the peoples of other nations. That there is a segment of our population, however, that may not be receiving all the benefits of modern medicine and hospitalization may be admitted, but that the remedy for this shortcoming is a national insurance scheme which would lower the standards of all to raise the standards of a few is certainly not reasonable.

Title IX at best is merely a device to allow Social Security to pay bills, thus providing minor alleviation of a financial need at the time of a present illness. It does not provide better health care in any manner, and in fact fails throughout its provisions as listed to advocate what would certainly be the best form of health social security—preventive medicine. On the contrary it proposes devices that would discourage prompt medical care when it stipulates that "the Surgeon General and the Social Security Board may determine that every individual entitled to general medical benefit may be required to pay a fee with respect to the first service or with respect to each service in a spell of sickness or course of treatment." This device to preserve the financial status of the Social Security funds finds no counterpart in present medical care where the medical profession places itself every day in the year at the disposal of the sick, regardless of the ability to pay a fee for service rendered.

Again, consider the ruling relative to hospitalization (SEC. 908) whereby hospitalization is denied the mental or tubercular patient, and SEC. 902 whereby the hospital stay in any instance is limited to 30 days. Yet the Blue Cross voluntary hospitalization program in Rhode Island today offers its members a minimum of 21 hospital days, and it will recognize also first admission for tubercular or psychiatric conditions.

Consider the provision of the act (SEC. 905 (2)) whereby specialist services would be available only on consent of the general practitioner, and realize that this provision gives the incompetent doctor and the doctor who does not keep abreast of the latest scientific advances a control over his patients to the extent that they could and would be denied the services of a trained specialist.

Can these phases of the program be construed as advances towards a better health for the people of our state and country?

Not only would the regulations of the act (to say nothing of what further restrictions might be imposed once an administrative force was authorized to supervise a nationwide program) result in a deterioration of medical care, but they would further discourage early diagnosis. The theory advanced that everyone would seek medical care if it were available at a low cost is fallacious, as has been proved by the experience of the Life Extension Examiners which, in serving the policyholders of 39 different life insurance companies, has examined approximately three million people during the past 25 years. These examinaations, given to policyholders at no cost to them, and the report in no way affecting existing contracts, offer an answer to whether the average person demands the preservation of good health while he still has it. The result of this free offer of periodic health examination is reported by Dr. Harry J. Johnson, director of Life Extension, as follows:

> "It has been our experience that only 5% of those entitled to the services avail themselves of the privilege. From our studies 80% of those who take advantage (i. e. of the 5%) of the service come in the smaller policy group, that is, those with less than $2,000 of life insurance, which would certainly indicate that the greatest interest in the service is found in those people in the lower income bracket."

Medical care is a service, not a commodity that can be purchased over the counter. Therefore, the mere distribution of funds to meet costs is not sufficient basis for the introduction of a national scheme which would disrupt all the advances made and being made on a voluntary basis. That certain parts of the country merit additional national support to bring them abreast to the more advanced sections is not disputed. But free choice as a principle should not be discarded merely because some sections cannot assure such choice actually.

We would strongly urge that our States seek ways to advance assistance to the people of any State to improve health conditions, provided such financial aid from a national pool is not used as a political gesture. There is much to be done in the improvement of public health in every State, and public funds undoubtedly must and should be utilized in every State to improve the health services for all and to assure the medically indigent of proper care. The greatest contribution that Social Security can make is in the work of preventive medicine. The Surgeon General himself has been reported as stating that if the appropriation for malaria control were doubled the disease could be eliminated in a short time. Likewise there is little doubt that the appropriation of sizable funds to augment those of state and private agencies could provide for research, hospitalization, and medical care which would make vast inroads on the control of tuberculosis, cancer, and equally serious diseases.

Title IX of the Wagner Act cannot, then, be considered as a panacea for the health problems of the nation. The good health of the individual depends on more than the mere possession of cash in the pocket to meet an emergency illness. It requires a well-rounded study of the family, its home environment, its food, its recreation, and its aptitude for accepting sound health education in preventive medicine. Man is master of his destiny, and as long as he chooses to ignore or neglect the sound advice to preserve his good health, then so long will we be faced with the illnesses from neglect and ignorance with the subsequent strains on the individual's economic status.

The Committee makes the further observation in this preliminary report that the controversy relative to the present Wagner Act brings forcibly to the attention of the medical profession once again the alluring picture that partisan groups, political or otherwise, can present to further their objectives. The challenge is there, and it remains for the medical profession throughout the country, and for our own State Medical Society in particular, to initiate a factual study of local facilities for health and medical care and to take the leadership in solving the health and medical problems of all our citizens, giving full thought to the utilization of private, state, and federal programs.

The Committee on Public Laws,

Chairman, WILLIAM H. FOLEY, M.D., LEWIS B. PORTER, M.D., HERMAN C. PITTS, M.D., HENRY E. UTTER, M.D., EMERY M. PORTER, M.D., EARL F. KELLY, M.D.

MATERNAL MORTALITY

COMMITTEE ON MATERNAL MORTALITY

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(With this issue of the JOURNAL *the Committee on Mortality presents a case report and discusses it for the benefit of the membership of the Society. As a form of post graduate medical education this type of presentation should be of great value to every doctor. THE EDITORS.)*

CASE HISTORY

PRIMI-GRAVIDA. Last menstruation June 5, 1940. Four ante-partum visits. First October 16, last January 3, 1941. Blood pressure 100/80, 90/50, 110/70. Urine normal. No gain in weight. Chronic cough for five years. A diagnosis of probable pulmonary tuberculosis was made and confirmed by x-ray. Admitted to State Sanatorium November 7 where repeated sputum examinations were negative for tubercle bacilli. Guinea pig inoculation was also negative. There was loss of weight, tachycardia, questionable exophthalmos, lid-lag, tremor, excessive perspiration and a metabolic rate of plus 37. Thyroid not palpable. She was discharged from the sanatorium as non-tubercular with a diagnosis of hyperthyroidism. Admitted to the hospital for observation and treatment January 3, 1941. Throughout her thirty-nine day stay in the hospital her temperature was normal as were her blood pressure, urine and leucocyte count. Hgb. 57% on January 4 and 72% on January 11. Sputum culture showed a predominance of green colonies probably streptococcus viridans. Blood culture was sterile. Repeated x-ray examinations showed no substernal thyroid, but varying degrees of soft infiltration of the upper lobes of both lungs; no cavity formation; prominence of the pulmonary artery and pulmonary conus; the aortic shadow was quite small suggesting congenital heart disease. Early examination by the cardiologist who made a definite diagnosis of mitral stenosis and regurgitation. There was pronounced tachycardia, orthopnoea and cyanosis. Her condition was serious throughout her stay in the hospital and at times alarming. Ligation of the poles of the thyroid was considered but was rejected because she was "too near term". Five weeks after her admission to the hospital and one month before her due date there was an apparent improvement in her condition which was felt was merely temporary. It was fully realized that she was a very poor surgical risk but as there seemed to be no probability that after five weeks of bed rest there would be any further improvement in her condition it was decided that she should be delivered. As x-ray pelvimetry showed a small gynecoid slightly flat pelvis, a rapid classical Caesarian section was done February 7 under spinal anaesthesia and a live baby weighing five pounds and ten ounces was delivered. Immediately after the extraction of the baby the patient developed cardio-vascular collapse and died within three minutes. No autopsy was permitted.

Cause of death: Hyperthyroidism, mitral stenosis, Caesarian section.

Discussion

In analyzing a fatality of this kind in retrospect it is easy to point out possible errors in management. There was no neglect in this case. The seriousness of the condition was recognized. All aids to diagnosis and prognosis were employed. Medical consultants were called in. If there were any mistakes in management they were errors in judgment.

It is easy to say that this or that should have been done but it is impossible to know whether the outcome would have been different if a different course of treatment had been followed.

However, this case, though the committee does not presume to criticise the way it was treated, does present some points which may be discussed with profit.

When the obstetrician calls in a medical or surgical consultant he should not abdicate his position as the one responsible for the final decision as to the obstetrical management of the case. The experienced obstetrical specialist sees many more com-

plications of pregnancy than any medical or surgical consultant. The physician is inclined to over estimate the strain of pregnancy and labor and under estimate the seriousness of therapeutic abortion. The cardiologist on the consulting staff of an obstetrical hospital is less and less likely to advise abortion in heart disease the longer he is on the staff and the more women with seriously damaged hearts he sees go through pregnancy and labor successfully after he had advised therapeutic abortion in the early months. Some surgeons hesitate to do an operation on a pregnant woman fearing that an abortion may result or, if she is near term that she will go into labor and an abdominal incision will give way. The obstetrician knows that the first stage of labor puts very little strain on the abdominal wall and the obstetrician can, if necessary, eliminate the second stage. If an abortion follows an operation it is more often the condition for which the operation was performed than the operation per se which causes the abortion. In acute abdominal conditions such as appendicitis, a uterine fibroid with a twisted pedical, an ovarian cyst or cholecystitis with impending gangrene, pregnancy makes the indications for immediate surgical intervention doubly urgent. It may be laid down that, as a general rule, the operations of elections may be postponed but that in any condition that demands immediate operation in a non-pregnant woman, pregnancy makes the indications for operation still more urgent.

In a complicated case such as the one here reported, there is a temptation for the obstetrician and equally for the consultant to avoid the responsibility of making the diagnosis which will determine the course of treatment. Should the patient be treated as a case of mitral stenosis or of hyperthyroidism? The committee is in no position to know whether there was divided responsibility in this instance but it is evident no decision was made until the patient was in the opinion of the obstetrician and the consultant "too near term" to justify an operation on the thyroid. The proper course to follow in a similar case would be to call in a competent surgeon and as soon as the diagnosis of hyperthyroidism was made, ask him not "do you advise operation for this woman" but, "if this woman were not pregnant would you advise operation". If the answer is "yes" that surgeon should operate and the obstetrician determine the subsequent obstetrical management.

Was this patient in fact "too near term" to justify an operation? If the operation had been successful and the patient gone to term would her condition in the intervening four weeks have improved? If the operation had been followed by premature labor would her condition have been worse than if she had not been operated?

Was the choice of the anaesthetic wise? In a patient with mitral stenosis and regurgitation and a heart overloaded by pregnancy and the tachycardia of hyperthyroidism would the danger of cardio-vascular collapse following emptying of the uterus been less if the operation had been done under local or general anaesthesia instead of under spinal?

Was Caesarian section the best method of delivery? The best opinion appears to be that Caesarian section puts a greater strain on a damaged heart than the first stage of labor and an operative delivery as soon as the cervix is fully dilated and retracted and the head is well engaged. This patient had a small, slightly flat pelvis. The presumed pelvic disproportion plus the heart condition were in this case the indications for section.

In every large obstetrical clinic the ease with which patients with serious cardiac decompensation are delivered is an ever recurring cause for amazement to the staff. In view of her apparently somewhat improved condition should this patient have been allowed to go to term with the hope that the heart condition would at least not deteriorate and the baby could be delivered without Caesarian section?

These questions are asked not in the belief that catagorical answers can be given but in the hope that they may indicate the complexity of the problem this case presented and suggest some general principles which should be followed in the management of obstetrical cases with medical or surgical complications.

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PATTERN OF STATE MEDICINE

When the Rhode Island Cash Sickness Act was written into the law the hope was expressed that it might set a pattern for the country as a sensible approach to the economic problem faced by the worker as the result of the loss of his wages due to unemployment because of illness. The public was told of the great benefits that would accrue to it as the result of the measure, and the medical profession, faced with the task of certifying illness, gave assurance that it would assist the Unemployment Compensation Board in its efforts to make the plan a success. Unfortunately the Board has never fully utilized the proffered assistance of the State Medical Society, and as a result the administration of the sickness act at the present time is far less satisfactory than would appear on the surface.

The fact that the General Assembly saw fit to contradict to some extent the original purpose of the sickness act, by opening it up to be utilized as an additional benefit to those already receiving workmen's compensation benefits, is no excuse for the Board to attempt to preserve the financial status of the fund at the expense of contributors. Its recent public report stating that more than 3,000 potential beneficiaries have been denied claims would indicate that such a situation exists.

In the first instance, consider the statement that out of about 6,000 persons ordered to appear for examinations before board physicians to support their claims for sickness benefits more than 1400—or nearly one-quarter—failed to put in an appearance. Therefor they were immediately denied further benefits. But why did so many fail to appear? Were they all malingerers? Or isn't it highly possible and probable that the majority of these people resented the idea of being called to a downtown office building at a stipulated time on a set date, there to be given a cursory examination before doctors strange to them who would on the spot decide whether or not the person could go to work?

What of the family physician who made the original diagnosis and who ordered a definite period of convalescence? Doesn't his opinion count after the first few weeks that benefits are paid? How many of the administrators of the program would be willing to submit to the cursory examination given by the Board physicians instead of complete care by the doctor of their choice? Little wonder, then, one-quarter of the persons ordered to report refused to do so, preferring to sacrifice their claims rather than to be treated in such manner. Of course such persons could appeal the action to the courts, provided they could afford counsel, time and the subsequent publicity to prove their claim for a few weeks of benefits.

Then, too, the report states that about 1,650 persons were denied benefits after examination. Why? Every claimant gets benefits solely on the certification of the physician of his own choice. Does the Board, then, imply that the doctors are falsifying the petitions for the claimants? If so, proper redress is available in the act to penalize the doctor. Certainly the claimant should not be denied continuance of benefits that rightly accrue to him as the result of his contributions, if he is unable to work because of illness. And his own physician should be the sole judge of his physical condition for return to work.

The idea of the sickness fund becoming a banking proposition whereby millions are pyramided to protect the solvency of the plan, at the expense of the wage earner who is ill now and needs immediate assistance, is contradictory to the whole idea as originally evolved. And the creation of a paid medical staff subject to the rules of the Board cannot, and must not, be construed as any endorsement whatever by the medical profession of Rhode Island of the procedures now being pursued to deny benefits.

SELECTIVE SERVICE REJECTIONS

No set of statistics has been subjected to more adverse publicity in the past decade than the Selective Service System figures of registrants physically examined and rejected at either local boards or induction centers . The magnitude of the problem became the concern of everyone interested in public health work, as well as those responsible for the administration of the Selective Training and Service Act of 1940.

But the ones who really capitalized on the figures were those groups seeking to prove, rightly or otherwise, that American Medicine had failed in its obligation to the people of the country, and that the health of America was indeed in a precarious condition. The public was alarmed by statements of such groups, and its concern was increased with the realization that these young men were below the age level at which degenerative diseases usually occur, and they had been drawn from useful occupations in civil life which they had followed without apparent handicap.

The assurances by medical and health authorities that the health of the nation was not "disgraceful", and that the rejection rates must be considered from several points of view, and not merely as basic figures indicting the youth of the country, contradicted some of the rash conclusions but they did not repair all the damage done.

The outstanding analysis, therefore, of the causes of rejection and incidence of defects, based on reports of physical examination from 21 selected states from November, 1940 through September 1941, issued by the National Headquarters of the Selective Service System, offers an excellent study of the entire problem. Of particular importance is the interpretation of the rejection rates which were as high as 52.8 per 100 registrants, white and negro combined. The report includes the following significant conclusions:

"However, several pertinent factors have often been neglected in public discussion of these rejection rates.

"(1) A large number of physically fit registrants chose to enlist in the armed forces without awaiting induction through the Selective Service System. If they had entered the armed forces through Selective Service the records would show larger number of inductions, the same number of rejections, and lower rejection rates.

"(2) Failure to meet the relatively strict standards then in force did not necessarily mean that the rejected man was seriously handicapped for a useful role in civil life or for many kinds of noncombatant service in the armed forces. Approximately one-half of the rejected men were classified as available for limited military service. Subsequently, with changes in physical standards, many limited service men were reclassified and inducted.

"(3) During peacetime it was not merely possible but desirable to set higher physical standards than in wartime. At that time the problem was not to raise a large Army; the Selective Training and Service Act provided that no more than 900,000 men should be "in active training or service in the land forces of the United States at any one time." The objective was to select and train the nucleus of an Army composed of men physically fit for any type of service and the standards were set accordingly. As an example of the difference between peacetime and wartime standards, registrants with syphilis and gonorrhea were not accepted for training and service during peacetime, and this elevated the rejection rate, particularly among the Negroes. Later, the standards were changed to permit acceptance of a considerable number of men with uncomplicated cases of syphilis and gonorrhea for treatment after induction. A further consideration that influenced the physical standards was the large

number of claims for service connected disability brought against the Government during and after World War I. In particular, the claims based on mental disorders, popularly but inaccurately termed "shell shock", had been so numerous and so costly that it was considered important to reject men who were likely to break down in service and become lifelong wards of the Government.

"(4) Under peacetime standards the proportion of registrants rejected because of failure to meet literacy standards, for moral reasons, or because they were aliens, was greater than under wartime standards."

When it is further noted that the high rejection rate noted above is for whites and negroes combined, and that the rate for the latter group is exceptionally high due to syphilis and failure to meet literacy standards, then the apparent ill health of our nation is a far cry from what was publicized in exaggerated claims made upon the first announcement of draft refusals. It is to be regretted that the opinions of the National Selective Service System in its recent study have not received wider recognition by the public.

"MAJOR SURGERY AND AMYLOIDOSIS"

The above title is the one given to an article by Dr. J. Murray Beardsley appearing in the August, 1943, issue of the *Journal of Thoracic Surgery*, pages 590 to 600. This article is recommended for reading and careful perusal by all physicians regardless of the field of medicine or surgery in which they may be interested. It is a splendid article clearly recording Dr. Beardsley's experience with a case of advanced amyloidosis in which he carried out multiple major operations in order to obliterate a focus of infection. He calls attention to the general belief that such procedures are unwarranted in the presence of advanced amyloidosis.

The case report of this patient which covers a period of treatment extending over a period of nine years reveals an example of courage and persistence. In spite of often discouraging circumstances, various stages of the operative procedures were carefully planned and successfully executed. It furthermore serves as an admirable guide to others who may be confronted with the duty of deciding the fate of patients afflicted with amyloidosis and who may be amenable to help by properly directed surgical procedures. The excellent result Dr. Beardsley obtained in his case fully attests the soundness of the view which he expresses in his paper, namely, for a most optimistic attitude in undertaking major surgical procedures in the face of severe amyloidosis.

TOMORROW'S CHILDREN

In order to improve health and control disease it is necessary to solve existing problems and anticipate new needs before these needs become problems themselves. The present health status of our community appears to be well controlled by the responsible agencies. There has been no cause for alarm in the recent spasmodic increase in poliomyelitis; the death rate from pulmonary tuberculosis continues to decline; venereal diseases do not constitute an unsolved problem; our usual seasonal epidemics of measles, whooping cough and chickenpox are no more alarming than before. It is obvious that to improve community health, efforts should be directed to the expectation of needs that will arise during the next few years. In anticipation of future problems, it would seem that strong consideration should be directed to the needs of children.

One of the most startling results of the present conflict is the definite sharp increase in the number of births throughout the United States. Rhode Island has kept pace with this national trend. In 1933 the number of resident live births recorded in the State was 10,341; in 1939 there were 10,368; in 1941, 11,430; in 1942, 14,105. The 1942 figure is approximately 36% more than that of 1939. This is indeed startling. It calls for serious thought about the health and welfare of these children.

To consider the problems that might be presented by a sudden large increase in children we must weigh the ability of the parent and the community to fulfill their respective obligations. The health of the child largely depends upon the social condition of the family which in turn largely depends upon the health of the parent. The parents of many of these births will necessarily comprise members of the armed services. The devastating effect of war will leave its impression on many of the fathers in service. It is inevitable that a number will return unable to dispense satisfactorily their responsibilities over the formative years of the children. Their defects will be manifested as traumatic disabilities, psycho-neurotic states and infectious or parasitic diseases. The major responsibility will then often fall upon the mother.

Here again, we will find a group who themselves, for one reason or another, will be unable to advance their child physically, morally and mentally along the ideal path to proud manhood and womanhood. In some of these instances the community itself will have to assume the entire burden for the care and development of the child. In the greater majority, however, the community will have to assume only part of the responsibility. It behooves us to examine our community facilities and determine if we are now able to help in solving these problems which are justifiably anticipated.

To breakdown anticipated needs of children, we might consider into what groups they themselves will fall. First, there will be children who, as mentioned above, will be thrown entirely upon the community for support. A second group might be those whom the community will have to share in developing. A third group will be those who are afflicted with one of the disabling diseases or deformities and who primarily will need health correction. Another group will be such as need care for certain periods in the year in order to improve their health. And, finally there will be some who should be removed from the home for certain lengths of time during the year, to provide a harassed and hard-working, or an ill mother, an opportunity to obtain for herself an essential vacation, rest or convalescence.

The problems of the first two mentioned groups are well recognized and certainly have been adequately cared for during recent years. We anticipate that the responsible groups will themselves foresee future needs and be prepared to handle the increased problems satisfactorily. The demand for the facilities which are now available for the second group might be taxed when the new births advance in age and become more susceptible to the menace of disabling illness and injury. Obviously we expect an increase of disease proportionate to the increase in children. The last mentioned group, however, may be that which could be given greater consideration than previously. In the more fortunate walks of life it is customary for the parents to take a vacation each year, frequently away from their children. It is obvious that an equal or greater health taxing burden is placed upon the less fortunate parent caring for several children. It is equally important with other problems that we provide opportunities for such mothers to obtain vacations several weeks each year, knowing her children will be placed in suitable environment.

Much of the national post war planning has appeared to devote itself to finances, the rehabilitation of soldiers and the return of industry and labor to peace time production, but little has been said of what we shall do to solve the problems of the vastly increasing number of children.

CORRESPONDENCE

The editorial entitled "Syphilophobia" in the September issue of the RHODE ISLAND MEDICAL JOURNAL called attention to the fact that lues is not as prevalent as we have been led to believe. There was the strongly implied opinion that not only have the dangers of syphilis been overemphasized, but that the campaign to educate the public has been overdone. Evidence was presented to indicate that lues is a problem in the negro rather than the white.

In compliance with the appeal which closed the editorial, "Let's get realistic about syphilis," are the following figures supplied by the Rhode Island Department of Health:

Reported Cases of Syphilis

Year	Total	White	Colored	Unknown
1940	1039	910	128	1
1941	1331	1156	166	9
1942	1327	1133	179	15

These totals do not include cases previously reported. During the decade 1932-1942 13,000 cases of syphilis were reported to the Health Department in Rhode Island. If these patients are treated over a period of years, many years in numerous instances, it is probable that there are at least 5,000 people in Rhode Island receiving antiluetic therapy at all times.

While it is true that the percentage incidence of lues is many times greater in the colored, it is clear that this *preventable* disease is present in this state in nearly 7 times as many whites. If the reverse were true, would the problem be of any less concern?

There is often a latent period in syphilis and many of the victims reported to the Health Department in Rhode Island have not suspected the presence of lues until one of its tragic and quite realistic manifestations, such as irreparable damage in the cardiovascular or central nervous systems, has occurred. The evidence published in the RHODE ISLAND MEDICAL JOURNAL for February, 1941, revealed that in the Syphilis Clinic at the Rhode Island Hospital 11.6% of the patients over 40 years of age suffered from cardiovascular lues. The manifestations of tertiary syphilis which were so prevalent 25 years ago *have* become much less

common: is this not due to the effectiveness of the therapy which has developed during this same period and to the more general use of serologic diagnosis?

It is known that early syphilis is curable usually. The manifestations of late syphilis can be avoided if the disease is discovered while in the latent stage. There are many reasons, economic as well as humanitarian, for the attempts to prevent and even to irradicate this disease. How can it be done other than by means of public education and universal blood tests? Are not the premarital blood tests a step in the right direction which should eventually result in a further reduction of the incidence of lues? If syphilis practically can be irradicated by having everyone's blood tested, and treatment given when indicated, should it not be done?

CLIFTON B. LEECH, M.D.

Providence, R. I.
September 10, 1943

Gentlemen,

A plea for the "detail" and drug salesmen .....

May I submit an earnest plea for publication in your Medical Journal addressed to all doctors?

We know how extremely busy the doctors are in these busy days. How well we know! Sitting in doctors' offices day in and day out—hours at a time—waiting our turn just as a patient does. Sometimes we are only able to make 2 calls an afternoon—and yet we are expected to produce, or else. Believe it or not, sometimes we are of great assistance to the doctor. He needs us as we need him.

May I make a suggestion? Whenever a doctor sees a detail man or a drug salesman in his office, let him come right in—tell the patient it is an important call, give the man 10 minutes and send him on his way. The doctor will not lose time as the percentage of salesman to patients is very small. He will be doing the man a great help—earn his respect and give that man a chance to earn his living just as the doctor.

Doctors, please give us a break.

Thanks,

"One of the Boys"

MEDICAL ADVISORY COMMITTEE TO O. P. A.

At the invitation of the State Director of the Office of Price Administration, the Rhode Island Medical Society has appointed a Medical Advisory Committee to assist the O. P. A. officials in their work of carrying out the war time regulations relative to rationing, particularly as regards the supplemental issuance of rationed commodities for which the physician's approval is required. The committee named by the Council of the Rhode Island Medical Society consists of Dr. John F. Kenney of Pawtucket, who will serve as chairman, and Drs. James H. Fagan and Robert H. Whitmarsh of Providence.

This Committee has already developed what it hopes may be a successful approach to the difficult problem of certification for rationed commodities for ill patients, and at the same time a satisfactory arrangement whereby the requirements stipulated by the physician in such instances may be reviewed by a medical appeal board whenever the certification is questioned by a local board.

Under the plan proposed by the new Medical Advisory Committee, and approved by the State Director of the Office of Price Administration, a uniform all-purpose certificate has been prepared which is being distributed in quantity to each physician. This all-purpose form will provide for certification for supplemental issuance of rationed foods, fuel oil, gasoline, and rubbers. Placing the certificates with the physician should serve as a better control of their use, and at the same time eliminate repeat visits to the physician's office by the patient merely for the purpose of having a certification form filled out.

The program outlined by the Advisory Committee provides that any physician's certificate may be questioned by a local board, but it may not be rejected until it has been reviewed by the State Director and the Medical Advisory Committee. Pending a decision from these authorities the local board shall issue temporary supplemental rations to the patient.

The certification should be signed by the physician ONLY when it is definitely shown that the patient will suffer in health because of the lack of the rationed commodity. It is readily apparent, therefore, that every physician in the State must assume an important obligation in accepting this program to assist the war price and ration boards in their efforts to assure eligible sick or disabled

continued on page 255

MEDICAL ADVISORY COMMITTEE TO STATE O. P. A.

continued from page 253

citizens necessary rationed commodities for the assurance of normal good health.

The uniform all-purpose certificate drafted by the Advisory Committee is as follows:

PHYSICIAN'S STATEMENT FOR SUPPLEMENTAL ISSUANCE OF RATIONED COMMODITIES

This statement subject to review and action by Medical Advisory Committee appointed by the Rhode Island Medical Society.

.....194.....
Month *Day* *Year*

.....
Name in Full of Patient

.....
Street Address

.....
City and State

STATE *FULLY* THE NATURE OF ILLNESS which *prohibits the use* of *non-rationed foods* and requires rationed foods *in addition to regular allowance* of the patient OR which requires warmer room temperatures:

.....

LIST THE ENTIRE AMOUNT OF
RATIONED FOODS REQUIRED BY PATIENT FOR THE FOLLOWING.....DAYS
(Not to Exceed 60 Days)

PROCESSED FOODS, JUICES & SUGAR	*Do not mark in these spaces*	MEATS & FATS	*Do not mark in these spaces*
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	

FUEL OIL

A room temperature of.....degrees is required for the patient for the following.....days (Not to Exceed 60 Days).

(to be filled in by Ration Board)

BOARD NO.....Date Issued.....
(points)

.....

.....

.....

.....D.O.
.....M.D.
Physician's signature

.....
Street Address

.....
City

Physician's statement certifying need of supplemental issuance of gasoline.....

Nature of illness which requires this additional ration and sign the face of this form.

.....

FOR USE BY MEDICAL SOCIETY ADVISORY COMMITTEE ONLY

Date Reviewed..... Comment:.....

.....

Signed:.....

STATEMENT OF R. I. MEDICAL SOCIETY ADVISORY COMMITTEE

.....

NOTE: All appeals must be returned to State Rationing Officer, Office of Price Administration, Hospital Trust Building, Providence, for final action.

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

OCTOBER MEETING

The Rhode Island Society of Industrial Physicians and Surgeons had their first meeting of the fall season in the Rhode Island Medical Library on October 19, 1943.

At this meeting they were joined by the Rhode Island Industrial Nurses Club. This organization was recently formed and works in close harmony with the Rhode Island Society of Industrial Physicians and Surgeons. It is planned that at all future meetings the nurses will meet at 8:00 o'clock and conduct their business from 8:00 to 8:30. Then the physicians will meet at 8:30 or 8:45, and after a short business meeting, both nurses and doctors will combine for a program of mutual interest.

The speaker of the evening at the last session was Mr. Robert Gillispie of the Walsh-Kaiser Company, who spoke upon the relationships in the plant of the physician and the safety engineer. Mr. Gillispie gave a splendid exposition of what might be accomplished by closer cooperation between the physician and his knowledge of accidents and accident prevention when combined with the ability of the safety engineer to eliminate hazards in and around the plant and peculiar to the occupation. He urged the physicians to know thoroughly all the hazards associated with the particular plants they served and to know best how to treat them and to assist the engineer wherever possible in eliminating serious accidents or continued occupational hazards. The meeting was extremely interesting and following the talk many physicians and nurses asked questions. A lively discussion ensued when several instances were recounted by physicians and nurses.

Following Mr. Gillispie the assembled doctors and nurses heard a talk by Mrs. Doris E. McGowan, of the Division of Women and Children, State Department of Labor, on labor laws as they concerned women and children in industry. Mrs. McGowan expounded at length on the responsibility for determining the age of children in industry. She stressed the fact that a birth certificate alone was not satisfactory proof or not acceptable proof by the Department of Labor that the child was sixteen years of age. The burden of proof rests upon the employer in every instance, and he is urged to accept as employees only those persons who have been certified by the School Department. Several instances of fraudulent age have been uncovered by investigators, and the doctors and nurses were warned as to the best procedures to follow in considering children for work that they are of the legal age and have the proper certificates issued by the school authorities. Mrs. McGowan's talk likewise provoked a lively discussion and a very profitable one.

Dr. Deery of the Department of Industrial Hygiene showed a motion picture in sound entitled, "Take Care of Yourself."

The meeting adjourned after the distribution of pamphlets covering various phases of industrial health work and some pamphlets from the United States Government National Committee for the Conservation of Manpower in War Industries.

EMPLOYMENT FOR PHYSICALLY HANDICAPPED

With the military forces making increasing demands on the services of young adult males and fathers in the middle age group, an increasingly greater number of older men and women will be employed in industry. What should our attitude

Industrial Physicians Meeting

Plans are now being made to hold the regular December meeting of the Society of Industrial Physicians and Surgeons of Rhode Island, and also the State Industrial Nurses' Association, at the Ashton plant of the Owens-Corning Fiberglas Corporation. A tour of this modern industrial plant will be followed by a business meeting there which will be addressed by an outstanding industrial health authority. Details on this important meeting will be sent to all members this month.

be toward their physical defects which they have had for many years and which have not been disabling until the time they applied for examination previous to employment in industry?

Wendell S. Keate, M.D., in the Douglas Aircraft Corporation of California, summarizes unusual findings in the September issue of "Industrial Medicine." He says in part "Qualified and limited employment has been substituted in place of rejection. With this procedure the acceptance of a potential hazard of a physical disability as well as inability is inevitable.

CLINICAL OBSERVATIONS

Obesity: When obesity is not complicated by cardiovascular disease it has proved to be acceptable in younger individuals. In older individuals in general, moderate to severe obesity has proved to be a personal hazard.

Hypertension: Applicants have been accepted with systolic pressures as high as 170 and diastolic pressures of 110 when no demonstrable, myocardial, or renal insufficiency was associated.

Valvular Heart Disease: In younger individuals where there is no myocardial insufficiency associated, this condition is not considered a basis for rejection.

Arteriosclerosis and Myocardial Disease: The degree of pathology and impaired physiology is difficult to determine from an objective examination. If there is no evidence of gross disturbance employment has been allowed.

Coronary Artery Occlusion: These types of vascular diseases offer industry a big headache. The condition indicated may become acute before it improves.

Varicose Veins: The existence of moderate or severe varicosities is a basis for rejection.

Herniae: Small hernia retainable by appliance has been accepted.

Pelvic Disorders: Cases of cystocele, fibroid, or ovarian tumors are basis for rejection. Pelvic inflammatory conditions found in young females have become a major problem.

Dermatoses: Applicants having demonstrable skin lesions should be closely scrutinized. Rejections for this group should depend upon the type of work which they are called upon to do. Psoriasis is not considered a basis for rejection."

More than ever before the pre-employment examination is now considered as a *pre-placement* examination. The aged or handicapped worker must be carefully selected for the job or rather the job must be carefully selected for the worker. He should also be given certain safeguards to be sure that any existent latent pathology will not become aggravated. It is also important to re-check these individuals at frequent intervals and thus to prevent the increase of disability and absenteeism in industry. We have got to resort to more careful scrutiny — more careful placement — more frequent check-ups of our over age or physically handicapped workers.

NEWS FROM THE WAR FRONT

7,000 DOCTORS NEEDED

The Office of War Information, in an official report issued on October 20, states that the Army and Navy lack adequate supply of civilian physicians, and assert they require an additional 7,000 medical doctors and 800 dentists "to insure even minimal care of the wounded" till the end of this year. The report was based on information from the Army, the Navy, and the War Manpower Commissioner's Procurement and Assignment Service.

Since March the Army has reduced its ratio to 6.6 doctors per thousand men in combat areas, and 4.6 doctors per thousand men in non-battle areas. The changed ratio works out to 53,000 civilian doctors for the Army and the Navy. Of these, about 46,000 had been commissioned as of August 15, but the commissioning of doctors into the armed services is falling behind the monthly quotas assigned.

According to OWI it was stated that many doctors, instead of asking for commissions, are waiting for their numbers to be called in the draft, when they feel sure of being commissioned despite the delay. It was pointed out on behalf of the Procurement and Assignment Service that this is a dangerous practice for the doctor. Application for commission on the eve of induction does not necessarily prevent a doctor from being drafted and undergoing basic training as a private in the Army, or as an apprentice in the Navy. Regular procedure would call for the doctor to remain in training until such time as his commission could be processed. Should he fail to receive a commission, he would continue on the same basis as untrained inductees. Several doctors have gone through basic Army training as privates.

FIRST WOMAN DOCTOR ENLISTS

Dr. Margaret M. Ross of Rumford, wife of Dr. Daniel J. McCarthy, an East Providence dentist, has the distinction of being the first woman doctor in Rhode Island to join the armed forces. Sworn in as a Captain in the U. S. Medical Corps last month, and subsequently assigned to the Post Hospital at Fort Des Moines, Iowa, Dr. Ross is one of the five women doctors in the country at this writing to hold the rank of Captain in the Army, and to be eligible thereby for duty on any war front.

"OUT OF 'JEEP' TRAFFIC"

A. P. O. 689, c/o Postmaster
New York City, N. Y.
September 28, 1943

The arrival today of the July '43 MEDICAL NEWS has prompted me to make a little report on this segment of the Society, isolated on a bluff in a dense mountain jungle. We thumb through the MEDICAL NEWS so avidly to learn the activities and whereabouts of our friends that I am sure, scattered all over the world, they are turning its pages with equal interest.

Capts. Wm. Leet, Geo. Conde, Fred Webster, John Dziob, Sam Clark and Irving Beck, with 1st Lts. Milton Korb and Wilbur Manter, under my command, have left northeastern India and are a two day march beyond the limits of jeep traffic. With us are Capts. I. E. Garber and Ed Greeninger (attached to the 48th as replacements while we were at Murfreesboro). With the appropriate enlisted personnel we form Field Hospital No. 1 of the 48th Evacuation Hospital, so are still under command of Lt. Col. William Mahoney, now commanding officer of the 48th, but he is still with that section running the Post Hospital back on the plains.

We are simultaneously erecting and running a 250 bed hospital, 90% Chinese soldiers as patients. The collection of bamboo sheds and huts under the huge trees of a primeval jungle would hardly be recognized as a hospital by those familiar with the great medical centers. But a hospital it is and a busy one with an enthusiastic personnel.

continued on page 263

Bill Leet comments that we have a "million dollar site, if it were in New England."

Yours sincerely,

ERIC STONE, Major, M.C.

EYES TOWARD BURMA

With the Indo-China campaign in the offing our 48th Unit must surely have its eyes toward Japanese-held Burma. Latest news, in addition to the letter from Major Stone, from India reveals that Colonel Leedham, who took charge of the Unit following its organization at Fort Devens, has been transferred, and our Lt. Col. William A. Mahoney is the C. O. The Unit has lost two now of its original group, as Drs. Arthur Martin, and Frank Holland, the latter dental officer, have returned to America, and following home visits have been assigned stations at camps here.

Meanwhile the Unit has reportedly acquired a Chinese Lieutenant Colonel who is attached to the surgical staff and who will undoubtedly be a key member in the invasion force. Major J. Murray Beardsley, ill with jaundice for more than a month, was last reported headed for Darjeeling, a mountain resort near Mt. Everest, where his convalescence will undoubtedly be speeded by rest within sight of the majestic Himalayas.

MILITARY ROUNDUP

CAPTAIN FRANCIS E. TEMPLE, MC, is reported to be somewhere in England with a unit which was formed when he was stationed at the Walter Reed Hospital. . . . CAPTAIN JOHN H. GORDON, MC, former secretary of the Pawtucket Medical Association, is reported to have been on the patient roster at a station hospital in Africa, following his participation in the Sicilian invasion. . . . MAJOR JOSEPH C. SMITH, MC, former deputy health officer in Providence, has been transferred from Mitchel Field to the Station Hospital at Langley Field, Virginia. . . . Promoted to the rank of Captain recently were DRS. DONALD DE NYSE, FRANCIS D. LAMB, and ARNOLD PORTER, the last named the son of Dr. Emery M. Porter, President of the Providence Medical Association. . . . MAJOR JEREMIAH A. DAILEY, MC, who spent more than a year at Waikapu in the Pacific, is now assigned to Camp Niantic in nearby Connecticut. . . . After a short stay at Camp Blanding, LIEUT. MAURICE N. KAY, MC, has been transferred to Camp Croft in South Carolina. . . . The new address of Oceanside, California, seems quite appropriate for LIEUT. NICHOLAS POURNARAS, MC, USNR, who was one of Block Island's two doctors at the time of his enlistment last January.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

LIEUT. CHARLES E. BRYAN, MC, Carlisle Barracks, Carlisle, Pennsylvania.

CAPTAIN EDWARD SELTZER, MC, Carlisle Barracks, Carlisle, Pennsylvania.

LIEUT. ALBERT J. GAUDET, MC, Carlisle Barracks, Carlisle, Pennsylvania.

CAPTAIN MARGARET ROSS, MC, Post Hospital, Fort Des Moines, Iowa.

TRANSFERS

CAPT. LOUIS A. BEAUDOIN, MC, 1621 SU, Fort Custer, Battle Creek, Michigan.

LT. COMDR. JARVIS D. CASE, MC, U. S. Naval Hospital, Charlestown, South Carolina.

MAJOR JEREMIAH A. DAILEY, MC, Station Hospital, Camp Niantic, Connecticut.

LIEUT. PHILIP S. GELLER, MC, O-302036, 709 Medical Hospital Ship Platoon, Camp Stoneman, Calif.

LIEUT. ALBERT E. GEREMIA, MC, USNR, U. S. Naval Medical Supply Depot, Pearl and Sands Streets, Brooklyn, New York.

CAPT. WALTER E. HAYES, MC, 28th General Hospital, Moore General Hospital, Sevannanoa, North Carolina.

LIEUT. MAURICE N. KAY, MC, 319th Station Hospital, Camp Croft, South Carolina.

MAJOR JOSEPH C. KENT, MC, Dispensary, 3rd Bn., Truck Regt., Fort Benning, Georgia.

CAPT. FRANCIS D. LAMB, MC, Army Air Base, Reading, Pennsylvania.

LT. COMDR. FRANK B. LITTLEFIELD, MC, Service Force, Att'n Fleet Subordinate Command, N. O. B., Norfolk, Virginia.

LIEUT. AMEDEO MASTROBUONO, MC, USNR, U. S. N. [redacted]/o P. M., San Francisco, Calif.

LIEUT. ADOLPH J. NADWORNY, MC-Af, Air Force Regional Station Hospital, Coral Gables, Fla.

LIEUT. NICHOLAS POURNARAS, MC, 4th Bn., 14th Marines, 4 T Marine Division, Camp Pendleton, Oceanside, California.

MAJOR JOSEPH C. SMITH, MC, Station Hospital, Langley Field, Virginia.

LT. COMDR. H. FREDERIC STEPHENS, MC, USNR, [redacted] Navy 140, c/o Fleet P. O., San Francisco, California.

LT. COMDR. ERNEST THOMPSON, MC, USNR, Navy 147, Fleet P. O., New York, N. Y.

LT. (j.g.) WILLIAM H. TULLY, MC, USNR, U. S. S. Wadleigh, Bath Iron Works, Bath, Maine.

LT. COMDR. HAROLD WILLIAMS, MC, U. S. Naval Training Station, Great Lakes, Illinois.

CAPT. MARK A. YESSIAN, O-502633, 239th Engineer Combat Battalion, Med. Det., Camp Forrest, Tenn.

PROMOTIONS

LIEUT. DONALD DENYSE promoted to the rank of Captain.

LIEUT. FRANCIS D. LAMB promoted to the rank of Captain.

LIEUT. ARNOLD PORTER promoted to the rank of Captain.

FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

NEW FELLOWS OF SOCIETY

There has been an excellent response to the appeal of the President to members of district societies who are not members of the State Society to register for fellowship at this time. Within the past month the following doctors have been enrolled as fellows of the Rhode Island Medical Society and thereby as members of the American Medical Association: Drs. James A. Alston, C. Thomas Angelone, Angelo Archetto, Vera M. Behrendt, George W. Bellano, Reginald H. Boucher, Temple Burling, Maurice J. Butler, Charles E. Bryan, Robert E. Carroll, Pasquale J. Celestino, George V. Coleman, Alfred Conte, Vera Winston Fish, Louis J. Fuhrmann, William P. Giles, Sidney S. Goldstein, Eugene N. Granger, H. Gulesserian, Albert C. Henry, William A. King, George E. Kirk, Anne L. Lawton, George R. Mankis, Joseph Marks, Morris Marks, Vincent J. Mattera, Francis H. McCaffrey, James P. McCaffrey, James F. A. McGinn, Llewellyn J. McGovern, James R. McKendry, Frank A. Merlino, Louis A. Morrone, Gustavo A. Motta, Rose C. Munro, Adolph J. Nadworny, John A. Paterson, Charles Potter, William A. Reid, Edward A. Ricci, Mildred I. Robinson, Vincent P. Rossignoli, Warren H. Ruhmann, John C. Sarafian, Ciro O. Scotti, James F. Sullivan, Ralph V. Sullivan, Adrien G. Tetreault, William H. Tully, Jr., Howard W. Umstead, Charles E. White, and Joseph E. Wittig.

HONORS CONFERRED

In recognition of thirty years as members, Dr. William M. Muncy and Harry C. Messinger, both of Providence, were elected senior members of the Academy of Ophthalmology and Otolaryngology at the annual meeting of the Academy in Chicago, October 10-12.

Cited for outstanding work in public health education, John E. Farrell, executive secretary of the Society and also of the Providence Medical Association, was one of six nominated by the Section on Public Health Education and subsequently elected to Fellowship by the Governing Council of the American Public Health Association. Mr. Farrell was also honored locally recently by election as 2nd vice president of the R. I. Conference of Social Work.

Dr. Peter F. Harrington, director of tuberculosis in the Providence Health Department, was appointed last month as Chairman of the Health Division of the Providence Council of Social Agencies.

Dr. Lucius C. Kingman, former president of the Society, has been named by the Mayor of Providence to fill the unexpired term of Dr. John M. Peters, resigned, as a member of the Board of Hospital Commissioners.

VISITORS FROM MEXICO

At the invitation of Dr. Clifton B. Leech, chairman of the Medical Advisory Committee for the Bureau for the Handicapped, a group of Providence doctors attended a luncheon meeting on October 6 for Drs. Rafael Moreno-Valle and Vincente Roqueni who were visiting the city by direction of the Minister of Public Health of Mexico for the purpose of obtaining ideas which will aid them in developing a rehabilitation program for adults in their country. The local delegation included, in addition to Dr. Leech, Drs. Herbert E. Harris, William A. Horan, Peter F. Harrington, Raymond F. Hacking, William P. Buffum, and the executive secretary, Mr. Farrell.

NEW HAMPSHIRE BLUE SHIELD

At its Fall meeting the House of Delegates of the New Hampshire Medical Society authorized its Committee on Medical Economics, which had reported a plan for statewide medical service on a voluntary non-profit basis, to make such changes as may be necessary and to put the plan into effect. The program will be known as the Blue Shield, and it will be directly operated by the State Medical Society which estimates it must raise ten thousand dollars to inaugurate the plan.

MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

DERMATOLOGY

Oliver S. Ormsby & Hamilton Montgomery—Diseases of the Skin. Phil., 1943. 6th ed. rev.

NERVOUS SYSTEM

Joseph L. Fetterman—The Mind of the Injured Man. Chic., 1943.

Studies of the VIII Nerve, by the Research Study Club of Los Angeles. St. L., 1937.

THERAPEUTICS

Logan Glendening & Edward H. Hashinger—Methods of Treatment. St. L., 1943. 8th ed.

SPECIAL GIFTS

Gift of CHARLES L. FARRELL, M.D.

Jack E. Weiss, editor & others—1021 Answers to Industrial Health and Safety Problems. Cleveland, Ohio, 1943.

FLAG PRESENTED TO LIBRARY

A silk American flag, one of the finest available, and a supporting standard topped with a gold eagle, was presented to the Library by Dr. Emery M. Porter, President of the Providence Medical Association, at the conclusion of the Association's regular meeting on October 4. The flag will be displayed from the platform in the auditorium on the occasion of medical meetings there.

The gift is singularly appropriate in these times when the defense of the flag is uppermost in everyone's mind, and the Committee on the Library, in behalf of the State Medical Society, acknowledges this important addition to the Library equipment with deep appreciation.

BOOK REVIEWS

NEW AND NON-OFFICIAL REMEDIES 1943. American Medical Association, 535 North Dearborn Street, Chicago, Ill.

This contains descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the A. M. A. on Jan. 1, 1943.

The material used in this book is carefully examined and used only if the facts as presented are proved to be true. A description of the drug action and uses, doses, tests and standards are also given. Besides the book itself, supplements are edited during the year which keep abreast with new and additional information.

For quick information this will prove to be an excellent reference book for any medical library.

METHODS OF TREATMENT — by Logan Glendening, M.D., and Edward H. Hashinger, A.B., M.D., both Clinical Professors of Medicine, University of Kansas. Eighth Edition.

An introductory note states that "this book is planned to furnish an outline of all the methods of treatment in internal medicine". Twelve collaborators have written chapters on special subjects. There are one hundred and thirty-eight illustrations. It is a sizable book of over one thousand pages in two parts with twenty-five chapters. Part I is devoted to general therapeutics, Part II to the application of therapeutics to particular diseases.

The authors frankly express personal views on controversial subjects: for example, "bromides properly administered are probably still the best drug we have for epilepsy". I do not believe this opinion will be generally accepted.

Of course in these days of frequent contributions to, and modifications of, therapy no bound volume can be up to the minute. The fact that this work has reached its eighth edition in two decades is an undeniable tribute. It is a valuable basic volume, especially for the general practitioner and internist.

WILLIAM S. STREKER, M.D.

Will the members who have the following journals from the Medical Library kindly return them at their earliest convenience as they have been requested:—

Archives of Neurology & Psychiatry, March 1943 War Medicine, February 1943.

DISTRICT SOCIETY REPORTS

KENT COUNTY

A meeting of the Kent County Medical Society was held at the home of the President, Dr. Arthur E. Hardy, on October 14.

The proposals of the House of Delegates of the Rhode Island Medical Society were read and discussed. It was voted that action on these recommendations should be taken at the next meeting.

Dr. Charles J. Ashworth, of Providence, associate surgeon at Rhode Island Hospital, read a paper on "Acute Surgical Conditions Within the Abdomen." Some of the conditions presented were acute appendicitis, chronic acute perforated peptic ulcer, acute pancreatitis with gall bladder infections, and peritonitis. Dr. Ashworth also reported signs, symptoms and differential diagnoses, and he related some personal cases with results. The paper proved very interesting to the members, and it evoked general discussion.

BENJAMIN F. TEFFT, M.D.,
Secretary

PROVIDENCE MEDICAL ASSOCIATION

The first regular meeting of the Providence Medical Association following the summer recess was held at the Medical Library on Monday, October 4.

The Secretary reported that tributes for the Association's permanent records have been filed with him as follows: By Drs. Frank T. Fulton, and Robert C. Robinson in memory of Dr. Murray S. Danforth; by Drs. Charles J. Ashworth and John G. Walsh in memory of Dr. Charles F. Gormly; by Dr. Halsey De Wolf and Lieut. Comdr. William P. Davis in memory of Dr. Frederic V. Hussey.

Twelve new members were elected to membership as follows: Active—Reginald H. Boucher, M.D., Charles E. Bryan, M.D., Robert E. Carroll, M.D., Walter R. Durkin, M.D., William P. Giles, M.D., John J. Lury, M.D., Llewellyn J. McGovern, M.D., Rose C. Munro, M.D., Adolph J. Nadworny, M.D., Warren H. Ruhmann, M.D., William H. Tully, M.D.; and Associate—Laurence A. Senseman, M.D.

Dr. Emery M. Porter announced the appointment of Dr. Philip Batchelder to fill the unexpired term of the late Dr. Murray S. Danforth on the Executive Committee of the Association.

The scientific program consisted of the presentation of two papers, the first by Dr. Louis Goodman of the State Hospital, on "Chronic Hypertensive Encephalopathy", and the second by Dr. B. Earl Clarke of the Rhode Island Hospital on "The Rh Factor: Its Role in Erythroblastosis of the Newborn and in Transfusion Reactions."

Dr. Goodman classified the causes of chronic hypertensive encephalopathy under three headings: The "h" or hormonal factor; the "c" or central factor; the "r" or renal factor.

He reported six cases with autopsy findings. The duration of life after onset of symptoms varied from ten months to thirty-one years. The basis of the disorder is arteriolarsclerosis with resultant areas of ischemia, edema and hemorrhage. He differentiated the condition diagnostically from brain tumor, schizophremia, cerebral arteriosclerosis and dementia paralytica. The paper was discussed by Dr. Earl Clarke and Walter Weigner.

A series of slides presenting graphically the mechanism by which the Rh factor causes intragroup transfusion reactions and erythroblastosis of the newborn was presented. Credit for preparing these graphic slides was credited to Dr. Edward S. Brackett.

It was pointed out that the erythroblastotic infants are produced entirely, or almost entirely, by Rh negative mothers and Rh positive fathers. The mother absorbs the Rh antigenic factor from the fetus. The anti Rh substance produced by the mother find its way to a certain extent into the circulation of the fetus, causing various hemolytic disorders. It was pointed out that an awareness of the Rh factor would eliminate about 90% of the intragroup transfusion reactions. A group of Rh negative donors should be available to all obstetrical services. Particularly the mother of an

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erythroblastotic fetus should be transfused with only Rh negative blood.

FRANK W. DIMMITT, M.D.,
Secretary

PAWTUCKET MEDICAL ASSOCIATION

A business meeting of the Pawtucket Medical Association was held at Memorial Hospital on Thursday, October 21. The recommendations of the House of Delegates of the State Medical Society were reported by Dr. James L. Wheaton, vice president of the Society. No action was taken on the recommendations.

WASHINGTON COUNTY

The regular meeting of the Washington County Medical Society met on October 13th at the Elm Tree Inn, Westerly, Rhode Island.

The report of the meeting of the House of Delegates on September 23, 1943 was read and also a letter from Dr. William P. Buffum asking for action on several matters relating to it.

The Society adopted the recommendation that all new members be required to join both the district and state medical societies at the same time. This has been our policy for several years.

Dr. Louis C. Cerrito was appointed to serve as a legislative officer to assist the Committee on Public Laws.

Attention was called to the appointment of Dr. Roland Hammond of Providence as chairman of the Committee on Medical Defense and Grievance.

Dr. B. Earl Clarke, Pathologist of the Rhode Island Hospital, was the speaker. His subject was, "The Sternal Biopsy; Its Application in the Diagnosis of Obscure Blood Conditions." It was illustrated by lantern slides of microfilms, first a group of normal blood slides and then those of aplastic and hyperplastic anemias, leukemias and tumors.

It was a carefully prepared and well presented paper, and it was greatly enjoyed by those present.

After the meeting sixteen members sat down to a fried chicken dinner.

JULIANNA R. TATUM, M. D.,
Secretary